The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children

SARA ROSENBAUM*
KATHLEEN A. MALOY**

The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 preserve and, in certain respects, expanded the Medicaid entitlement for families with children. By failing to restructure Medicaid, however, federal lawmakers left intact the eligibility standards and enrollment procedures that had been in use under the repealed Aid to Families with Dependent Children program (AFDC). By failing to modernize Medicaid eligibility standards and enrollment procedures to meet the demands of a new "work-instead-of-welfare" environment that replaced the "welfare-to-work" paradigm that underlay AFDC, lawmakers effectively assured a long-term decline in Medicaid coverage for families with children. This decline is already well underway. Furthermore, states have only begun the fundamental program restructuring necessary to the preservation of Medicaid as a major and viable source of coverage for low income workers and their families.

I. INTRODUCTION

As the White House and Congress completed negotiations over the final welfare reform legislation[1] early in August 1996, much of the health policy community breathed a collective sigh of relief because negotiators rejected[2] inclusion of provisions passed by both Houses that would have converted Medicaid from an individual entitlement into a block grant.[3] Moreover, in order

---

* Harold and Jane Hirsh Professor, Health Law and Policy Director, Center for Health Services Research and Policy, The George Washington University Medical Center, School of Public Health and Health Services.

** Associate Research Professor, The George Washington University Medical Center, School of Public Health and Health Services.

[1] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

[2] *See* H.R. CONF. REP. NO. 104-725, pt. 46, at 291–92 (1996), *reprinted in* 1996 U.S.C.C.A.N. 2649, 2679–80 (requiring states to provide "Medicaid to all persons who would be eligible for AFDC cash benefits").

[3] *See, e.g., id.*; HOUSE COMM. ON COMMERCE, H.R. REP. NO. 104-651, at 323–74 (1996), *reprinted in* 1996 U.S.C.C.A.N. 2235, 2235–87; COMM. ON COMMERCE, MINORITY & ADDITIONAL VIEWS, H.R. REP. NO. 104-651, at 2018–22 (1996), *reprinted in* 1996 U.S.C.C.A.N. 2235, 2614–18. A block grant is a type of law that authorizes the expenditure of a

to avert declines in Medicaid coverage as a result of the elimination of Aid to Families with Dependent Children (AFDC),[4] the conferees agreed to require states to continue to use their existing AFDC standards as the minimum basis of Medicaid coverage.[5] Thus, while the successor Temporary Assistance for Needy Families (TANF) block grant vested states with almost unfettered latitude over cash welfare payment policy, Medicaid appeared to be "saved."

What most health policy analysts did not understand—and came into clearer view only well after the enactment of welfare reform—was the major impact that the repeal of AFDC would have on Medicaid. Indeed, the effects of the changes became apparent only as the Medicaid program and federal census data began to show sharp declines in the number of beneficiaries.[6]

The failure of health policymakers to grasp the vast implications of welfare restructuring for Medicaid (even if the individual entitlement was saved) is not hard to understand. The root of the problem lies in the intricate structural and methodological relationship which Medicaid and cash welfare historically have maintained and the extreme difficulties that arise in any effort to disentangle Medicaid and welfare. In much of the health policy debate that surrounds Medicaid, these rules essentially remain out of view, since most of the analysis available on Medicaid concerns coverage and expenditure patterns for enrollees and "recipients."[7] Exactly how a person comes to be a "recipient" is a focus for

---

defined amount of funding by a unit of state or local government. A block grant creates no individual entitlement to benefits on the part of persons served by programs funded through the block grant. *See generally* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C.) (providing an example of block grant legislation in the Temporary Assistance to Needy Families (TANF), which replaced the Aid to Families with Dependent Children (AFDC) program in 1996). Had Congress converted Medicaid into a block grant, the beneficiaries would have lost their federal entitlement to health coverage.

[4] *See* Social Security Act of 1935, ch. 531, tit. IV §§ 401–03, 49 Stat. 620, 627–29, *repealed by* Personal Responsibility and Work Opportunity Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

[5] *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(I) (1994).

[6] *See* U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, P60–208, HEALTH INSURANCE COVERAGE 1 (1998) (reporting "the number of uninsured children was 11.1 million in 1998 or 15.4 percent of all children"). The most notable increase in the number of uninsured children occurred among children under age six; the proportion of uninsured children in this age group rose from 20.1% to 23.6%. *See* Robert Pear, *Number of Americans Who Were Uninsured Rose in 1998, U.S. Says*, N.Y. TIMES, Oct. 4, 1999, at A-1. The youngest children (infants and children under age six) are the most likely to be eligible for Medicaid. *See* PAUL FRONSTIN, EMPLOYEE BENEFITS RESEARCH INSTITUTE, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED 23 tbl.12 (1998). In 1997, 27% and 25.4% of infants and children ages one through six, respectively, received Medicaid, compared to 20.5% of all children under age 18. *See id.*

[7] *See, e.g.*, FRONSTIN, *supra* note 6, at 23; DIANE ROWLAND ET AL., A REPORT OF THE

only a handful of health services researchers, typically individuals with welfare law and policy backgrounds. Thus, the evidence suggests that neither the Congressional Budget Office (which estimated that only nominal Medicaid caseload changes would occur as a result of welfare reform)[8] nor White House and Congressional negotiators saw what was coming.

Medicaid is an essential part of the nation's health care financing system. In calendar year 1990, the program accounted for 11.3% of total personal health care expenditures.[9] A major source of funding for both primary and acute health services as well as long term care, Medicaid is particularly important for families with children. In 1996, the program covered twenty-five percent of all infants and young children[10] and ten percent of all women ages eighteen to sixty-four.[11] In light of the limited availability of employee health benefits for low income workers and their families, the need for Medicaid is obvious.[12]

Medicaid's sheer size makes it an important source of healthcare financing. Widespread erosion in Medicaid coverage would reverberate throughout the American health care system, further jeopardizing the financial stability of health care institutions and diminishing already limited access to health care among uninsured Americans who in 1998 comprised 16.3% of the U.S. population.[13]

This Article examines the consequences of welfare reform for Medicaid. It also assesses the restructuring in Medicaid that will be required if the program is

---

KAISER COMM'N ON THE FUTURE OF MEDICAID, MEDICAID AT THE CROSSROADS 5–12 (1992) (discussing the cost of Medicaid and who is eligible to receive aid); DAVID LISKA ET AL., STATE-LEVEL DATABOOK ON HEALTH CARE ACCESS AND FINANCING 131–54 (3d ed. 1998) (providing data on various aspects of each state's Medicaid program, including eligibility, enrollment, participation, and expenditures).

[8] *See* Letter from June O'Neill, Director, Cong. Budget Office, to Jacob J. Lew, Acting Director, Office of Mgmt. & Budget 6 (Aug. 9, 1996) (on file with authors) (estimating that "[i]n general the bill retains categorical eligibility for Medicaid families that meet the eligibility criteria for AFDC as they are in current law.... Overall the CBO judge[d] that there would be no significant budgetary effect of the [TANF] block grant on the Medicaid program.").

[9] *See* CONGRESSIONAL RESEARCH SERV., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) 2 (1993) [hereinafter MEDICAID SOURCE BOOK].

[10] *See* ALINA SALGANICOFF ET AL., CHILD HEALTH FACTS: NATIONAL AND STATE PROFILES OF COVERAGE 13 fig.2 (1998).

[11] *See* THE COMMONWEALTH FUND, HEALTH CONCERNS ACROSS A WOMAN'S LIFESPAN: 1998 SURVEY OF WOMEN'S HEALTH 33 (1999).

[12] *See* ELLEN O'BRIEN & JUDITH FEDER, HENRY J. KAISER COMM'N ON MEDICAID & THE UNINSURED, EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE AND ITS DECLINE: THE GROWING PLIGHT OF LOW WAGE WORKERS 4 (1999). In 1993, only 36% of workers earning less than $5.00 (the minimum wage) worked in firms that sponsored a health plan, compared to 92% of workers earning $15 per hour or more. *See id.* at 4 fig.4. In 1993, only 27% of all workers in the lowest wage quintile had employer coverage. *See id.* at 8 tbl.3.

[13] *See* Pear, *supra* note 6, at A-1.

to be a viable source of coverage for low income families with children. This Article considers the two distinct problems that the enactment of welfare reform created for Medicaid. The first was an exacerbation of a serious, but relatively well-known "back end" phenomenon, which occurs when people who leave welfare also are terminated from Medicaid, even though they continue to qualify for coverage. This problem is as old as Medicaid itself; it emanates from Medicaid's welfare "piggyback" structure, which makes it vulnerable to improper cessation when welfare payments cease.[14] To the extent that the 1996 legislation intensified the cessation of benefits, this back end problem appears to have deepened.[15]

The second problem, which is more difficult to measure or analyze, is a "front end" phenomenon that appears to have developed throughout the country. This front end problem can be summed up as either the failure to enroll in Medicaid at all or a delay in enrollment until serious health needs are present. Failed and delayed enrollment patterns have numerous repercussions. The most obvious is a loss of any coverage among low income children and parents. A somewhat less obvious, but equally serious consequence, could be a decline in the proportion of healthy enrollees and a concomitant increase in the proportion of enrollees with health problems if low income working families fail to enroll at all or else delay enrollment until a family member is ill. If such an enrollment pattern emerges, it could spell the end for approaches to coverage such as risk-based managed care arrangements, which, like any insurance system, depend for their stability depends on a large pool of healthy members.

Because of its long term implications, it is the front end dilemma that may be of greatest concern.[16] Some individuals ascribe this front end problem either to a failure on the part of eligible families to understand their ability to qualify for Medicaid or an unwillingness to apply.[17] However, the erosion in Medicaid is a deep structural problem that cannot be dismissed simply as family ignorance or

---

[14] *See generally* Sara Rosenbaum, *Summary Termination of Medical Benefits to Aged, Blind and Disabled Persons: Perils of a Piggyback Entitlement Program*, 2 CLEARINGHOUSE REV. 404 (1978) (providing an overview of the long-standing nature of this problem).

[15] *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAID ENROLLMENT: AMID DECLINES, STATE EFFORTS TO ENSURE COVERAGE AFTER WELFARE REFORM VARY 24 (1999). This 1999 report on welfare's effects on Medicaid enrollment found that in the states selected for study, the percentage of families who continued to be enrolled in Medicaid during the 12-month welfare to work transition was as low as 4%. *See id.*

[16] *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MEDICAID: EARLY IMPLICATIONS OF WELFARE REFORM FOR BENEFICIARIES AND STATES 19 (1998) (expressing concern over the number of eligible children and families who did not enroll in Medicaid) [hereinafter MEDICAID: EARLY IMPLICATIONS]; Shailagh Murray, *Drop in Food-Stamp Rolls is Mysterious and Worrisome*, WALL ST. J., Aug. 2, 1999, at A-20 (discussing a report by the General Accounting Office showing a decrease in food stamp use due to poor public information).

[17] *See* MEDICAID: EARLY IMPLICATIONS, *supra* note 16, at 19.

resistance to enrollment; indeed, evidence suggests that Medicaid expansions aimed at pregnant women and low income families with children have been met with great enthusiasm among eligible families.[18]

The erosion in Medicaid coverage can be understood only as a structural phenomenon that related to lawmakers' decision to use AFDC criteria to determine Medicaid eligibility. Two separate sets of consequences, one substantive and one procedural, flowed from this decision. As this Article will show, in preserving Medicaid's substantive ties to the repealed AFDC program, lawmakers effectively dictated that eligibility be considered in accordance with standards intended for use in a program designed to reach a nonworking population. States would effectively have to administer two separate welfare systems: one for cash welfare and one for Medicaid. Rather than redesigning the program to meet the practical needs of persons who work instead of receiving welfare, Congress essentially chose to continue the program as an add-on benefit for nonworkers (*i.e.*, AFDC beneficiaries), even as the ability to secure assistance without working was disappearing. This Article will further underscore that while Congress included in the 1996 legislation state options to reconfigure their Medicaid programs to better meet the needs of low income workers, these changes were optional. By 1998, almost no states had pursued them.[19] Thus, as welfare reform altered the essential nature of welfare, welfare offices, and the welfare application process, Congress effectively left the Medicaid program behind.

To the extent that Medicaid policy and procedures remain wedded to outdated welfare theory, its long term stability remains in doubt; indeed, the decision on the part of lawmakers to "freeze frame" Medicaid by preserving eligibility based on defunct AFDC standards threatens to "end Medicaid as we know it." A fundamental overhaul of Medicaid eligibility standards and enrollment procedures is necessary to preserve the program as a viable source of coverage for families with children.

Part II begins with a brief overview of Medicaid coverage for families with children and reviews the structure of the program during the 1965–1996 time period. Part III discusses the 1996 welfare reform legislation and the Medicaid amendments that accompanied it. This Part considers both the basic Medicaid eligibility rules adopted under the welfare reform legislation, as well as the provisions that allowed—but did not require—states to make the necessary changes in Medicaid to conform the program to the realities of the new welfare environment. Part IV examines diversion, the heart of the new welfare system, as well as the extent to which state Medicaid agencies, using the 1996 legislative

---

[18] *See generally* U.S. GEN. ACCOUNTING OFFICE, PRENATAL CARE: EARLY SUCCESS IN ENROLLING WOMEN MADE ELIGIBLE BY MEDICAID EXPANSIONS (1991).

[19] *See infra* note 50 and accompanying text.

options made available to them, have responded to this shifting welfare structure. The Article concludes in Part V with an assessment of the Medicaid restructuring that will be needed if the program is to survive in the new welfare system as an insurer of working families with children.

II. MEDICAID COVERAGE FOR FAMILIES WITH CHILDREN (1965–1996)

Medicaid[20] is a federal grant-in-aid program that entitles individuals who satisfy its eligibility requirements to "medical assistance" coverage for a wide range of medical care items and services.[21] States administer Medicaid under broad federal standards relating to eligibility, benefits, provider participation and payment, and administration to receive a federal contribution. In 1999–2000, the federal contribution toward states' medical assistance expenditures ranged from fifty to eighty-three percent of total state medical assistance outlays.[22] Medicaid is an open-ended entitlement to states, without an upper limit on total federal contributions, either on an aggregate or per-capita basis. However, states place limits on their Medicaid expenditures that are in accord with their own budget constraints.

Both the largest and most complex of all federal means-tested public assistance programs, Medicaid is a central part of the American health care financing system. In Fiscal Year 1995, Medicaid enrolled over thirty-six million nonelderly children and adults—nearly sixteen percent of the U.S. population.[23] Total state and federal Medicaid expenditures that year exceeded $133 billion.[24]

A complete discussion of Medicaid is beyond the scope of this Article.[25] However, it is important to understand its basic structure in order to appreciate the effects of the 1996 law. From the time of its original enactment in 1965, Medicaid has effectively functioned as three distinct programs. First, Medicaid provides coverage for certain impoverished families with children, low income pregnant women, and low income children under age nineteen. The program specifically extends twelve months of transitional coverage for persons needing AFDC for three out of six months prior to losing cash assistance as a result of increased

---

[20] *See* Social Security Act, 42 U.S.C. § 1396 (1994 & Supp. III 1997).

[21] *See* 42 U.S.C. § 1396a(a)(10) (1994).

[22] Medicare & Medicaid Guide (CCH) ¶ 14,905, at 6471 (1999).

[23] *See* DAVID LISKA ET AL., *supra* note 7, at 138 tbl.D-1 (referring to the Medicaid eligibility enrollment and program participation of the nonelderly from 1994 to 1995).

[24] *See id.* at 144 tbl.D-5 (referring to the Medicaid enrollees expenditures and expenditures per enrollee by enrollment group).

[25] *See generally* MEDICAID SOURCE BOOK, *supra* note 9 (providing perhaps one of the best overall discussion of Medicaid).

earnings.[26] Second, the program covers children and adults with disabilities who receive Supplemental Security Income (SSI);[27] the program also extends coverage to certain disabled workers who no longer qualify for SSI.[28] In this capacity, Medicaid not only assures coverage for children and adults who might otherwise be excluded from health insurance plans because of a disability, but also pays for long term care in both institutional and community settings, which typically is not covered by private health insurance.[29]

Third, Medicaid acts as a companion insurance program to Medicare by paying Medicare's premiums, deductibles, and copayments for eligible low income Medicare beneficiaries.[30] For the poorest beneficiaries (those who receive SSI benefits for elderly or disabled persons), Medicaid provides full supplemental coverage for services and benefits such as prescribed drugs and long term care that are not covered by Medicare.[31]

This description of Medicaid is a vast over-simplification. Medicaid's extraordinary complexity arises from the fact that, rather than covering all low income persons, the program covers more than fifty distinct categories of low income and medically impoverished individuals and families. Each separate category can best be understood as a response to some form of "market failure" (the failure or unwillingness of the insurance industry to offer an affordable health care product).[32] As with many U.S. laws that compensate for market lapses, the Medicaid statute operates like a series of legislative incisions rather than in a broadly remedial fashion, providing relief only to the extent deemed necessary to compensate for a particular cost or coverage deficiency in the private market.

In terms of its detailed eligibility structure, Medicaid traditionally has been first and foremost a companion to cash welfare benefits. With certain limited exceptions that are not relevant to this Article,[33] children and adults who received financial aid under either of the two principal federal cash welfare programs

---

[26] *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(I),(III),(IV),(VI),(VII) (1994).

[27] *See* 42 U.S.C. § 1382 (1994). The SSI program is a federally administered cash welfare program that provides financial assistance to individuals who meet federal criteria related to age, disability, and blindness and who also satisfy federal financial eligibility standards. *See id.*

[28] *See* Social Security Act § 1905(q), 42 U.S.C. § 1395(q) (1994).

[29] *See generally* RAND ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM (1997 & 1999–2000 Supp.) (providing a general discussion of the differences between Medicaid and private insurance).

[30] *See* 42 U.S.C. § 1396a(10)(A)(i)(II).

[31] *See id.*

[32] *See* ROSENBLATT ET AL., *supra* note 29, at 410–66 (providing a discussion of Medicaid as a response to market failure).

[33] *See* Medicare & Medicaid Guide (CCH) ¶¶ 14303-14381, at 5981–6230 (1999) (giving a complete overview of current Medicaid eligibility standards).

(AFDC[34] and SSI[35]) were automatically entitled to Medicaid. In 1995, more than fifty-six percent of all Medicaid beneficiaries also received some form of federally assisted cash welfare.[36] Because of this tie to cash benefits, Medicaid historically was highly dependent on, and sensitive to, the underlying dynamics of the welfare system. Even as Medicaid coverage was liberalized over the years to cover additional groups of low income children and adults (including all children and pregnant women with income at or near the federal poverty level)[37] and welfare recipients in the process of transitioning to work,[38] its links to welfare were maintained. These links were particularly evident in the application system as well as the standards and methodologies by which applicants' income and resources were evaluated and financial eligibility was determined.

Thus, even as Medicaid coverage was extended to children and adults ineligible for AFDC (either because of a lack of categorical ties to welfare or excess earnings), Congress nonetheless preserved the link to welfare for the new coverage groups by requiring states to apply the same methodologies used to evaluate income and resources under the AFDC program.[39] Despite widespread popular perception that the Medicaid expansions for children, pregnant women, and welfare-to-work families "broke the link" between AFDC and Medicaid, this perception was only partially correct. It is true that these coverage expansions broadened the categories of persons eligible for Medicaid and raised the income and resource standards against which applicants' eligibility would be measured.[40]

---

[34] *See* Social Security Act, ch. 531, tit. IV §§ 401–03, 49 Stat. 620, 627–29, *repealed by* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

[35] *See* 42 U.S.C. § 1381 (1994).

[36] *See* HENRY J. KAISER COMM'N ON THE FUTURE OF MEDICAID, MEDICAID EXPENDITURES AND BENEFICIARIES, NATIONAL AND STATE PROFILES AND TRENDS, 1990-1995, at 9 fig.2 (3d ed. 1998).

[37] *See infra* note 40 and accompanying text.

[38] *See supra* note 26 and accompanying text.

[39] *See* 42 U.S.C. § 1396a(a)(17)(B) (1994).

[40] In 1996, the average AFDC standard for a family with no other income stood at 34% of the federal poverty level. *See* U.S. HOUSE OF REPRESENTATIVES, COMM. ON WAYS & MEANS, 105TH CONG., 1998 GREEN BOOK 416–17 tbls.7–8 (Comm. Print 1998). By setting the income eligibility standard at 100% of the federal poverty level (and higher in the case of pregnant women, infants, and children under age six), the reforms of the 1980s led to the expansion of coverage for children and pregnant women. Between 1990 and 1995, the number of children receiving Medicaid, but not cash assistance, increased by 17.6% annually on average. The number of children receiving both Medicaid and cash grew by only 3.4% per year on average during this time period. For a general discussion of the Medicaid reforms for women, children, and former recipients of welfare, see Sara Rosenbaum, *Medicaid Expansions and Access to Health Care*, *in* MEDICAID FINANCING CRISIS: BALANCING RESPONSIBILITIES, PRIORITIES, AND DOLLARS 45, 45–81 (Diane Rowland et al. eds., 1993).

At the same time, however, welfare methodologies were retained for income evaluation purposes.[41] Furthermore, as was the case for welfare recipients, state welfare agencies continued to be designated as the entities that would determine eligibility for Medicaid, even in the case of persons who were not eligible for welfare and had no intention of applying for welfare.[42]

The importance of restructuring Medicaid to make it a more effective means of covering poor working families is not a new concept. Medicaid amendments enacted in 1988 gave states the option to adopt more liberal methodologies for evaluating income in the case of low income children and pregnant women who qualified for Medicaid on the basis of income alone.[43] This amendment gave states the flexibility to move decisively away from AFDC methodologies for evaluating income in structuring their Medicaid eligibility standards—at least in the case of children.

The need to move away from AFDC eligibility methodologies in calculating Medicaid coverage becomes evident once the basic premise and structure of AFDC is examined. AFDC was conceived in 1935 as a program that provided subsistence to families with virtually no other income. Moreover, in calculating "net income," applicants' earnings are counted almost in their entirety at the point of application; the only earned income deduction available is a nominal $90 earned income disregard.[44] This minimum deduction for applicant earned income is sufficient if the underlying program concept is to aid only those people who do not work.[45] If the goal is to aid lower income workers, then the deduction is totally inadequate, since even low wage earners make several hundred dollars per month.[46]

Once AFDC recipients enter the work force, the earnings disregard rises somewhat, thereby allowing recipients to work and retain welfare and

---

[41] Federal regulations require that in determining eligibility for Medicaid, states must apply "the cash assistance financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status." 42 C.F.R. § 435.601(a) (1998).

[42] Section 1396(a)(55) requires state Medicaid agencies, as a condition of receipt of federal funds, to allow certain groups of individuals—including low income children and pregnant women—to file applications at certain outstationed locations, including federally qualified health centers and hospitals that serve a "disproportionate share" of low income and Medicaid beneficiaries. *See* 42 U.S.C. § 1396a(a)(55) (1994). No study has ever quantified the proportion of all beneficiaries who enroll in outstationed locations, but a study of outstationing suggests only limited implementation of the requirement.

[43] *See* 42 U.S.C. § 1396a(r)(2), *amended by* Medicare Catastrophic Coverage Act of 1988 § 1396a(r)(2), Pub. L. No. 100-360, 102 Stat. 963 (1988).

[44] *See* 45 C.F.R. § 233.20(a)(ii)(B) (1998).

[45] *See id.*

[46] A minimum wage job at 40 hours per week would result in monthly gross earnings of approximately $800.00.

Medicaid.[47] AFDC recipients who finally lose their welfare benefits because their remaining earnings exceed allowable levels are entitled to receive extended Medicaid coverage as long as they received AFDC in three out of the six months preceding their loss of welfare.[48]

In sum, AFDC methodologies are calibrated to applicant families who initially do not work and then gradually earn their way off welfare. Applying AFDC methodologies to working families who effectively would disqualify most poor workers at the point of application, since without application related disregards, their earnings would exceed eligibility levels.[49]

The 1998 amendments thus permitted states to adopt more liberal methodologies for the treatment of earned income, thereby allowing the program to reach more children. In fact, however, few states responded to this option; as of 1998, only a handful of states had taken advantage of the flexibility offered by the amendments.[50] This limited response was probably the result of several factors. First, liberalizing eligibility standards adds program costs. States already incurred additional costs in responding to the expanded coverage mandates for poor children; few states could have been expected to go beyond the federal minimum and serve additional children through a liberalized income test.

Some of the failure to respond to the option may also be traceable to federal administrative practices. The Health Care Financing Administration, the federal agency which administers Medicaid, provided no guidance regarding the 1988 legislation.[51] Furthermore, in many states, officials tend to have only a limited knowledge of Medicaid eligibility. This is because as a matter of federal law, it is welfare agencies, not Medicaid agencies, that oversee enrollment and make eligibility determinations.[52] Medicaid agencies simply pay for the cost of the eligibility determination process. While state Medicaid agencies possess expertise

---

[47] The disregard for working welfare recipients amounts to $30 plus one-third of the remaining earned income. *See* 45 C.F.R. § 233 (1998). This is commonly known as the "30 and a third" disregard.

[48] *See* 42 U.S.C. § 1396r-6(b)(1) (1994).

[49] *See infra* Table 1.

[50] A few states did expand coverage of children as part of larger demonstrations conducted under section 1115 of the Social Security Act, which grants the Secretary broad powers to permit states to extensively restructure their Medicaid programs. Section 1115 coverage expansions are typically accompanied by offsetting reductions in spending in other areas of the program, as well as implementation of mandatory managed care. *See* SARA ROSENBAUM ET AL., HENRY J. KAISER COMM'N ON MEDICAID & THE UNINSURED, SECTION 1115 MEDICAID WAIVERS: CHARTING A PATH FOR MEDICAID MANAGED CARE REFORM 184–86 (1999).

[51] The only formal guidance can be found at State Medicaid Manual 3503, *reprinted in Supporting Families in Transitions: A Guide to Expanding Health Coverage in a Post-Welfare Reform World*, Medicare & Medicaid Guide (CCH) ¶ 14,521.27, at 5964.

[52] *See* 42 U.S.C. § 1396a(a)(5) (1994).

in the areas of benefit coverage, provider qualifications and compensation, institutional quality oversight, and other matters related to the service aspect of the program, Medicaid officials, as a group, tend to be relatively unfamiliar with the operational issues of Medicaid eligibility. [53]

Thus, experience with Medicaid leading up to the 1996 welfare reform legislation suggested that most states did not take advantage of earlier options to revise welfare standards and methodologies in order to open the program to additional children in low income working families. The cost of exercising such an option may have been an issue. An equally important factor may have been a failure on the part of officials to understand either the significance of the liberalized methodology options that Congress made available or the impact of welfare methodologies on working applicants.

III. THE 1996 WELFARE REFORM LEGISLATION

A. *Overview of the Act: State Authority to Change the Welfare Paradigm*

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)[54] was perhaps the most far-reaching welfare legislation since the 1935 passage of the Social Security Act. The Act placed new restrictions on SSI for children,[55] child care,[56] child nutrition, and food stamps[57] and placed major limitations on the eligibility of legal alien residents for Medicaid and other forms of means-tested public assistance.[58]

The centerpiece of the PRWORA, however, was the repeal of AFDC and its replacement with a successor program known as Temporary Assistance to Needy

---

[53] *See* VERNON K. SMITH ET. AL., HENRY J. KAISER COMM'N ON MEDICADE & UNINSURED, THE DYNAMICS OF CURRENT MEDICAID ENROLLMENT CHANGES: INSIGHTS FROM FOCUS GROUPS OF STATE HUMAN SERVICES ADMINISTRATORS, MEDICAID ELIGIBILITY SPECIALISTS, AND WELFARE AGENCY ANALYSTS 13–15 (1998).

[54] Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

[55] Specifically, the Act modified provisions relating to the definition of disability among children to restrict coverage for children with physical, mental, and developmental disabilities and conditions. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended at 42 U.S.C. § 1382 (1994)).

[56] *See* 42 U.S.C. §§ 601–02 (Supp. II 1997).

[57] *See* Pub. L. No. 104-193 §§ 701–42, 801–16, 110 Stat. 2287-2318 (1996).

[58] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 401, Pub. L. No. 104-193, 110 Stat. 2105, 2261 (1996). For an overview of immigration law changes and their implications for Medicaid, see SARA ROSENBAUM & JULIE DARNELL, KAISER COMM'N ON MEDICAID & THE UNINSURED, AN ANALYSIS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996: IMPLICATIONS FOR MEDICAID AND HEALTH PROGRAMS 10–14 (1997).

Families (TANF).[59] Like AFDC, TANF entitles states to annual, aggregate federal payments to support the provision of financial assistance to certain needy families with children. Unlike AFDC, however, TANF does not create an individual entitlement to cash assistance among eligible persons.[60] Because TANF is not an entitlement, states have the discretion to deny assistance even to families that meet program eligibility requirements.

TANF gives states broad latitude over conditions of eligibility and enrollment procedures and safeguards. Federal law does set certain outer limits on state program design; these limits are designed mainly to ensure the imposition of work requirements as a condition of eligibility,[61] prohibition on aid to certain categories of persons,[62] and lifetime limits on the receipt of aid.[63] At their option, states may adopt more stringent limits and may add conditions of eligibility.

In the context of this Article, states' ability to place conditions on the right to apply for aid represents the single most important conceptual aspect of the 1996 legislation. Nothing in the 1996 law prevents a state from barring aid completely or even from prohibiting individuals from filing applications for assistance. Thus, while the authority (and indeed, the duty) to limit aid to a fixed period of time garnered much of the attention paid to the legislation by the popular press, it was this flexibility to prohibit entry into assistance at all that had far more long-lasting effects. Indeed, it is this threshold right on the part of the states to halt entry into welfare through the use of pre-application or pre-enrollment conditions that is essential to moving away from the old construct of "welfare-to-work" and toward the new paradigm of "work-instead-of-welfare."

A measure of the importance of this front end authority under the law is the dramatic decline in welfare enrollment since enactment of the legislation. Between 1996 and 1998, the number of individuals receiving cash assistance declined by forty-one percent nationally, compared to a nine percent decline between 1993 and 1996.[64] A vibrant economy undoubtedly would have caused welfare rolls to decline (a phenomenon that tends to occur during economic recovery and growth cycles). But the phenomenal drop in assistance that occurred in the years following welfare reform probably cannot be explained simply as the result of a good economy or the back end loss of benefits. This type of drop can be understood only as a consequence of states' authority to prevent new entrants

---

[59] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, 2210 (1996).

[60] *See id.* § 103, 110 Stat. 2104, 2113 (codified at 42 U.S.C. § 601 (Supp. II 1997)).

[61] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 103, Pub. L. No. 104-193, 110 Stat. 2105, 2129 (1996) (codified at 42 U.S.C. § 607 (Supp. II 1997)).

[62] *See id.* § 103, 110 Stat. 2105, 2134–40 (codified at 42 U.S.C. § 608(a) (Supp. II 1997)).

[63] *See id.* § 103, 110 Stat. 2105, 2137–38 (codified at 42 U.S.C. § 608(a) (Supp. II 1997)).

[64] *See infra* Table 1.

from taking the place of exiting beneficiaries through the use of front end barrier techniques known as "diversion," which is discussed in Part IV. Thus, although a healthy economy could cause a downward movement in the welfare rolls generally and back end limits could reduce the duration of welfare coverage, neither approach by itself or in combination with the other could achieve the overall reduction in enrollment that followed the enactment of the PRWORA.

B. *The Medicaid Amendments in Welfare Reform*

As noted, the conferees rejected legislative proposals to convert Medicaid into a block grant.[65] Furthermore, concerned over the effects of new and more restrictive TANF eligibility standards on Medicaid, the conferees adopted amendments that were intended to offset the possibility of declining Medicaid coverage as a result of TANF. Under the amendments, states would be required to continue to use their AFDC standards in effect on July 16, 1996 to determine Medicaid coverage for AFDC-related families.[66] This amendment, which was added at section 1931 of the Social Security Act, placed an eligibility floor under the Medicaid program in order to prevent automatic Medicaid reductions simply as a byproduct of possible welfare reductions and restrictions.

Beyond setting a Medicaid eligibility floor tied to 1996 AFDC standards, section 1931 contained two Medicaid state plan options.[67] First, the law permitted states to increase their AFDC-related income eligibility standards by an amount equal to the percentage increase in the Consumer Price Index over the same time period.[68] Second, section 1931 created a methodology liberalization option similar to the provision enacted in 1988 for poverty level children, and pregnant women. This option allowed states to adopt "income and resource methodologies that are less restrictive than the methodologies used under their State plan" as of

---

[65] *See supra* note 3 and accompanying text.

[66] *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 114, Pub. L. No. 104-193, 110 Stat. 2105, 2177–78 (1996) (codified at 42 U.S.C. § 1396v-1 (Supp. II 1997)). Section 1931 also allows states to roll back their AFDC standards to May 1, 1988 levels. *See* Social Security Act § 1931(b)(2)(A) (codified at 42 U.S.C. § 1396u-l(b)(2)(A) (1994)).

[67] Section 1931 also permitted states to maintain the Medicaid eligibility criteria utilized as part of an approved section 1115 welfare demonstration. Section 1115 demonstrations cannot be undertaken simply as a state plan option. A state must apply for approval of a specific demonstration, which must satisfy the Secretary's content and evaluation requirements. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 103, Pub. L. No. 104-193, 110 Stat. 2105, 2157–58 (1996) (codified at 42 U.S.C. § 615 (Supp. II 1997)).

[68] *See id.* § 103, Pub. L. No. 104-193, 110 Stat. 2105, 2178 (1996) (codified at 42 U.S.C. § 1396v-1(b)(2)(B) (Supp. II 1997)).

July 16, 1996.[69]

This second provision was crucial: like the 1988 option, it allowed states not merely to increase existing income standards, but to actually alter the methodologies used to evaluate family income and resources in ways that would result in greater eligibility for Medicaid, particularly in the case of working families. Thus, as with the 1988 option, states could use their section 1931 authority to increase the size of the "earned income disregard" for working applicant families, effectively making the entire family eligible for Medicaid. In sum, section 1931, like the predecessor provision aimed at low income children, permitted states to overcome the AFDC program's historic methodological barriers to coverage of low income working families. The option would apply to all categorically eligible family members (single working mothers and their children and two-parent families meeting a state's unemployment test).[70]

Section 1931 can be viewed as an amplification of Congressional expectations, first evidenced in 1988, that states would convert their Medicaid programs to systems capable of aiding the working poor. However, the amendment was only optional; states could elect to retain their 1996 AFDC standards as an ongoing basis of eligibility for families with children. Crucially, neither Congress, the White House, nor the Congressional Budget Office viewed a state's decision to retain its AFDC standards as anything other than one to maintain the status quo.[71] No one imagined that such a decision ultimately might be implicated in widespread declines in coverage. As it turned out, by retaining AFDC as the basis of eligibility rather than moving to a new set of "methodologies," Congress and the White House may have helped create the barriers to Medicaid coverage that Congress sought to avoid through the liberalization option provisions of the 1996 amendments.

As discussed in Part IV, the old AFDC standards and methods that are designed to get aid to nonworkers created a Medicaid program that is at direct odds with the new work-instead-of-welfare paradigm. When these two world views—welfare-to-work and work-instead-of-welfare—met up in the welfare reform implementation process, the results proved to be far-reaching and unanticipated. Furthermore, although the means for overcoming this problem existed (states could use section 1931 to move Medicaid off the old AFDC paradigm and into conformity with the new welfare system), it was not until 1999—three years after the legislation—that the Health Care Financing

---

[69] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 103, Pub. L. No. 104-193, 110 Stat. 2105, 2178 (1996) (codified at 42 U.S.C. § 1396v-1(b)(2)(C) (Supp. II 1997)).

[70] Federal regulations defining unemployed families give states considerable flexibility to use liberal tests of unemployment that result in the classification as unemployed of two-parent families. *See* 45 C.F. R. § 233.10 (1998).

[71] *See supra* note 8 and accompanying text.

Administration, which administers the program, first issued extensive guidance on the use of section 1931 to aid the working poor.

It is important to note that while section 1931 gave states the flexibility to address the methodological problems created by retention of the AFDC formulas that disfavor applicants with earnings, it did not alter the basic application system for Medicaid. Left untouched by welfare reform were the provisions of the statute that required eligibility determinations to be made by welfare agencies. Furthermore, the requirement that states offer enrollment in certain "outstationed" Medicaid application locations (application sites other than the local welfare office)[72] was not expanded. The law also did not alter states' practice of linking welfare and Medicaid applications, even though in states whose TANF standards departed from their 1996 AFDC eligibility criteria.

In short, beyond creating attractive options for expanding coverage, neither Congress nor the Clinton Administration gave much if any consideration to the ways[73] in which a changing welfare paradigm could affect Medicaid benefits. Neither Congress nor the Administration considered how a changing welfare system would fundamentally alter the atmosphere or functioning of welfare offices themselves, where Medicaid applications would continue to be filed and considered.[74]

IV. STATE WELFARE DIVERSION PROGRAMS AND STATE MEDICAID AGENCY RESPONSES: RESULTS OF A STUDY OF STATE DIVERSION TECHNIQUES AND MEDICAID PROGRAM DESIGN CHOICES

A. *An Overview of Diversion*

The new welfare paradigm of work-instead-of-welfare is achieved through state diversion programs. As discussed, the old paradigm consisted of entry into assistance, followed by job training and placement, with a gradual shift into work.[75] Diversion entails never entering into formal and ongoing assistance systems at all.

Diversion is a concept that is used to describe a variety of techniques for deferring or delaying the receipt of welfare. The philosophical basis of diversion is the belief that never entering welfare to begin with is the most important technique for promoting selfsufficiency. Whether diversion achieves long term

---

[72] *See supra* note 42 and accompanying text.

[73] *See infra* Table 1 (summarizing dynamics of Medicaid access prior to and following the 1996 welfare reform amendments).

[74] The changing dynamics of Medicaid access before and after welfare reform are summarized *infra* in Table 2.

[75] *See supra* notes 44–51 and accompanying text.

selfsufficiency is unknown; what is evident, however, is that the technique has a powerful impact on initial enrollment.

Unlike traditional welfare-to-work strategies that aim to help families make the transition to work after their application for assistance is approved, or after they have received benefits for a specified period of time, post-PRWORA diversion programs aim to keep families from receiving (and even applying for) welfare in the first place.[76] By expanding the requirements that families must meet in order to be eligible for assistance and providing more targeted assistance to address their needs, diversion programs have the potential to dramatically alter state approaches to providing assistance to poor families with children.

Beginning in 1997, the George Washington University School of Public Health and Health Services undertook a multi-year study to understand diversion and agency responses to diversion Medicaid.[77] For purposes of the study, we broadly defined formal diversion program authorities explicitly designed to address the immediate needs of families seeking cash assistance in ways that avoid enrolling families into a state TANF program.[78] We investigated the prevalence of three types of diversion programs and activities that fit these criteria: (1) lump sum payment schemes; (2) mandatory applicant job search requirements; and (3) exploration of alternative resources.[79] States may employ one, two, or all three approaches.

1. *Types of Diversion Programs*

a. *Lump Sum Payment Programs*

Lump sum payment programs provide families with a one-time cash payment in lieu of ongoing TANF assistance and are designed to keep families with a short term financial need from ever entering the welfare system. These programs are usually targeted to applicants who are already working or who have immediate job prospects.[80]

---

[76] *See* SARA ROSENBAUM ET AL., INITIAL FINDINGS FROM A NATIONWIDE STUDY OF OUTSTATIONED MEDICAID ENROLLMENT PROGRAMS AT FEDERALLY QUALIFIED HEALTH CENTERS 4–5 (1998) [hereinafter OUTSTATIONED MEDICAID ENROLLMENT PROGRAMS].

[77] This study was supported by the Robert Wood Johnson Foundation and the United States Department of Health and Human Services.

[78] *See* OUTSTATIONED MEDICAID ENROLLMENT PROGRAMS, *supra* note 76, at 4.

[79] *See id.* at 11.

[80] *See infra* Table 2 col.3 (totaling 20 states).

b. *Mandatory Applicant Job Search Programs*

Mandatory applicant job search programs require applicants to conduct job searches (ranging from several days to several weeks) before TANF benefits are authorized. These programs are designed to serve two purposes: (1) to encourage job-ready applicants to find employment quickly in an effort to reduce their need for ongoing assistance; and (2) to send a clear message that program expectations have changed. Applicants for assistance who fail to meet the job search requirements have their applications for assistance denied. Some states also have implemented voluntary applicant job search programs.[81] These programs may be more narrowly targeted than mandatory programs. Most importantly, applicants in voluntary programs who do not complete the job search requirements do not have their applications for assistance denied.

c. *Alternative Sources of Support Systems*

Alternative sources of support systems are used by some states as means of encouraging families to look elsewhere before submitting a TANF application.[82] Exploration of alternative resources is intended to discourage families from applying for cash assistance if other assistance is available to them and to help them think more broadly about how they can draw upon resources in their communities and families during times of need. Using this approach, states also have attempted to respond more directly to families' specific needs rather than encouraging them to apply for all benefits for which they might be eligible.

2. *Nationwide Survey to Determine Prevalence of Diversion*

In the initial phase of our study, we conducted the first national survey to determine the prevalence of diversion programs.[83] As of the summer of 1998, thirty-one states had implemented at least one diversion program. Twenty states were operating lump sum payment programs, with three additional states planning to implement such programs by the end of 1998.[84] Sixteen states required TANF applicants to engage in active job searches before their applications for assistance were approved.[85] Seven states were using an

---

[81] *See id.* at col.4 (totaling 16 states).

[82] *See id.* at col.3 (totaling 7 states).

[83] *See* OUTSTATIONED MEDICAID ENROLLMENT PROGRAMS, *supra* note 76, at 7–11.

[84] *See infra* Table 3.

[85] *See id.*

aggressive approach to help TANF applicants identify alternative resources.[86] Most states operating formal diversion programs had implemented only one program.[87] Twelve states had implemented lump sum payment programs only and ten states had implemented mandatory applicant job search requirements only. Only three states had implemented all three forms of formal diversion.

In the second phase of our research, we conducted case studies of diversion programs in five states. We found that the design and implementation of diversion programs reflected state and local goals and philosophies, and that of the three types of formal diversion, mandatory applicant job search represented the fastest growing program with the greatest potential to divert large numbers of families.[88] Findings also suggested that diversion has substantial potential to reduce initial access to Medicaid, particularly as families increasingly bypass welfare altogether or else go to work quickly.

3. *Potential Effects of Diversion on Access to and Eligibility for Medicaid*

There are three primary ways in which diversion programs may affect applicants' access to Medicaid. First, if applicants are not aware that their eligibility for Medicaid is not linked to their eligibility for cash assistance, they may not apply for Medicaid or complete their Medicaid applications because they believe their applications for TANF will be denied. Second, because of the historical link between eligibility for cash assistance and Medicaid, eligibility workers, unless instructed to process applications for TANF and Medicaid separately and carefully monitored, may deny an application for Medicaid based on failure to comply with a TANF work requirement. They may also fail to inform applicants about alternative options for Medicaid coverage, especially in the case of children who are eligible based on poverty alone as a result of the eligibility expansions discussed in Part II. Third, by forcing more rapid work, diversion programs may raise applicants' income above the AFDC-related Medicaid eligibility threshold, making them ineligible for Medicaid assistance.[89]

For example, lump sum payment recipients may be rendered ineligible for Medicaid if this payment is counted as income in the month of receipt. As Table 1 indicates, most states' threshold AFDC-related eligibility standards are low; a lump sum payment intended to address an immediate need may, if not disregarded, disqualify an applicant. Similarly, mandatory applicant job searches could mean that many families find jobs quickly. As a result, they may be Medicaid-eligible for one or two months at most—or perhaps not at all if their

---

[86] *See id.*

[87] *See id.*

[88] *See* OUTSTATIONED MEDICAID ENROLLMENT PROGRAMS, *supra* note 76, at 6.

[89] *See infra* Table 1.

earnings exceed the "standards of need" shown in Table 1—and will immediately lose their Medicaid coverage due to earned income. These families will also lose the opportunity for transitional Medicaid assistance because they will not have received Medicaid for three months prior to losing eligibility. This will also be true for lump sum recipients.

The extent to which diverted families receive Medicaid will depend upon several factors including whether states: (1) adequately inform families of their right to apply for Medicaid even if they do not apply for or are not eligible for cash assistance; (2) establish procedures to assure that applications for Medicaid are accepted and processed even if an individual cannot apply for TANF or does not meet all of the requirements to be eligible for TANF benefits; and (3) exercise their section 1931 liberalization options and revise their AFDC criteria to conform to the needs of applicants with either earned or lump sum income.

4. *Section 1931 Options for Ameliorating Impact of Diversion*

As discussed in Part III, section 1931 provides states with a series of options for ameliorating the effects of diversion. States can exercise these options to establish less restrictive standards and methodologies for determining Medicaid eligibility for diverted families who otherwise might be rendered ineligible. For example, families participating in lump sum payment diversion instead of enrolling in TANF may become ineligible for Medicaid upon receipt of a lump sum payment, which can be as much as the equivalent of three months of TANF benefits. Using its section 1931 option, a state may specifically disregard the lump sum payment in determining Medicaid eligibility.

Similarly, mandatory applicant job searches will likely mean that many families get jobs quickly, perhaps before applying for or enrolling in TANF, or probably within a month or two of enrolling. Consequently, families required to find work quickly may be eligible for Medicaid for one or two months at most or not at all if their incomes exceed the standards shown in Table 1. Moreover, because of their shortened period of Medicaid enrollment, families could lose their opportunity to receive an additional six to twelve months of transitional Medicaid assistance because they failed to be enrolled for three out of the six months preceding their loss of welfare. Again, using the less restrictive methodologies option, states can choose to disregard entirely the first three months of earned income for Medicaid eligibility purposes. This approach would help working families both initially qualify for and retain Medicaid eligibility for a sufficient period of time to trigger transitional Medicaid assistance.

In sum, if diversion programs continue to grow in number and are successful in diverting families from cash assistance, then a growing number of eligible families may effectively lose the opportunity to enroll in Medicaid. Furthermore, if AFDC-related Medicaid standards are not altered, then working families could be disqualified from any aid. States can avoid both results by altering their

application procedures and by exercising their section 1931 authority to help liberalize Medicaid eligibility criteria. Making these changes, however, requires that state officials be aware of the potential effects of diversion programs on access to Medicaid and understand the potential value of section 1931 to ameliorate these effects. The second phase of our study was to determine the extent to which state Medicaid agencies in states with diversion programs were using their legal authority to address these issues.

B. *Methodology*

For the Medicaid phase of the diversion study, we used a nationwide point-in-time descriptive research methodology. We contacted all thirty-one states previously identified as offering diversion programs and requested their participation in a structured telephone survey. We asked states to designate an official who is familiar with Medicaid eligibility policy issues for participation in the survey. In the five states selected for additional site visits,[90] we collected information in person and by telephone. We conducted the interviews with state officials over a six-month period, from June through November 1998. Of the thirty-one states operating a formal diversion program, twenty-nine participated fully in the survey.[91]

We designed a survey with nine open-ended questions to collect information about states' Medicaid policy decisions and implementation of their diversion programs. Our survey was designed to address several basic areas: how states implemented section 1931; whether and how they addressed Medicaid eligibility issues raised by their diversion programs; the extent of coordination between state human services officials and state Medicaid officials regarding Medicaid eligibility policies; states' Medicaid outreach and education efforts; and the degree of emphasis placed on providing health insurance to working poor adults.

Analyses and findings are based on discussions with state officials familiar with current state Medicaid policies, review of section 1931 state plan amendments (SPA) for twenty-five states, review of relevant HCFA documents and guidance, and analysis of additional data collected as part of the project.

It became evident to us that reliance on any one source of data would be insufficient. For example, HCFA has issued several letters to state Medicaid directors about how to interpret their authority and options under section 1931.[92]

---

[90] These states were Georgia, Maryland, Missouri, Montana, and Ohio.

[91] Project staff were unable to schedule an interview with Oklahoma officials during the six-month study period. An Idaho official responded to our questions in writing, but did not participate in the telephone interview. Consequently, project staff collected only partial information.

[92] *See* Search of Health Care Financing Administration, Center for Medicaid and State Operations Internet Information Site, (visited Nov. 23, 1999) <http://www.hcfa.gov/medicaid/

In accordance with one HCFA policy, states operating federal welfare reform demonstrations that contained a Medicaid component at the time of the enactment of the 1996 legislation were required to submit a section 1931 SPA describing the extent to which their demonstration criteria would be incorporated into their general, operational state Medicaid plans. HCFA officials indicated that states which did not submit a section 1931 SPA were assumed to be operating their Medicaid programs without section 1115 demonstration waivers and were simply continuing their basic AFDC methodologies and standards in effect as of July 16, 1996.[93] We reviewed the SPAs submitted by twenty-five states in order to evaluate the design of their section 1931 programs.

Although reviewing the section 1931 state plan amendments provided the most direct evidence of the options that states took under section 1931, it became evident from our conversations with state officials that gauging their understanding of the practical effects of welfare reform was critical to evaluating the design of their section 1931 programs. It also became evident that certain states which had failed to properly submit their SPAs in fact understood the effects of diversion on Medicaid coverage and adjusted their Medicaid policies accordingly. For example, several states with lump sum payment diversion programs disregarded lump sum payments in determining Medicaid eligibility, even though the use of the disregard was not codified in their section 1931 SPAs.

C. *Findings*

1. *Provisions of States' 1931 SPAs*

Of the thirty-one states operating diversion programs, twenty-one states[94] had, at the time of our study, received approval of their state plan amendments; state plan amendments in eight states[95] were under review. Three states[96] reported that they had not submitted their state plan amendments. Table 4 presents detailed information about each state.

---

medicaid.htm> (search for records containing "MEDICAID INFORMATION (INCLUDING BALANCED BUDGET ACT OF 1997) FILE" in I WANT TO SEARCH THE field and "SECTION 1931" in I WANT TO SEARCH FOR field).

[93] States for whom submission of SPA is mandatory are those states that were using alternative standards and methodologies for their Medicaid programs as part of their welfare demonstration waivers.

[94] These states were Arizona, Arkansas, California, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Minnesota, Missouri, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Texas, Washington, and Wisconsin.

[95] These states were Alabama, Colorado, Indiana, Maine, Missouri, Montana, South Dakota, and Utah.

[96] These states were Maryland, Virginia, and West Virginia.

2. *Lump Sum Payment Diversion*

Of twenty states using lump sum diversion, eleven states had approved section 1931 state plan amendments.[97] Of these states, only Arkansas specifically disregarded lump sum payments in its section 1931 state plan amendment. This provision represents a policy change. Previously in Arkansas, lump sum payments were counted as income in the month of receipt. Two other states—Wisconsin and North Carolina—elected to disregard assistance received under the state TANF plan. Wisconsin's policy was not limited to its Job Access Loan program (which the state does not consider to be a diversion program), but applied to any payment made to a client. North Carolina's draft amendment excluded all cash assistance payments made under the state TANF plan. These provisions may or may not have been intended to include lump sum diversion payments.

In the other states, officials reported that lump sum payments did not count toward Medicaid eligibility, despite the fact that their state Medicaid plan amendments did not indicate that lump sum payments would be disregarded. For example, Florida's state plan amendment did not specifically disregard the lump sum payment; however, officials reported that persons who receive lump sum payments must be TANF eligible and therefore Medicaid eligible. It was unclear how Florida's section 1931 Medicaid eligibility criteria addressed the federal AFDC-related requirement that lump sum income be counted entirely in the month of receipt. Failure to overcome this AFDC-related rule by using the section 1931 "more liberal standards and methodologies" option would immediately disqualify individuals from Medicaid, given the degree to which a lump sum payment would exceed AFDC-related Medicaid eligibility standards for a family of that size. Similarly, state officials in Iowa reported that lump sum payments were disregarded for Medicaid eligibility purposes, but their state plans did not indicate the inclusion of a disregard.

In the event that lump sum payments are not disregarded, states can take certain steps to ameliorate the potential impact of counting these payments. For example, in Minnesota, in which lump sum payments can be substantial (as much as $2800), state officials reported that lump sum payments may be prorated and treated as income in the month received and as an asset thereafter. Minnesota's resource level was set at a relatively high level of $3000. Minnesota's section 1931 state plan amendment, however, did not include a provision describing this approach.

---

[97] These states were Arkansas, California, Florida, Iowa, Kentucky, Minnesota, North Carolina, Ohio, Texas, Washington, and Wisconsin.

Among the five states with state plan amendments under review,[98] Colorado's, Maine's, and South Dakota's SPAs did not include provisions that disregard lump sum payments. Colorado proposed to increase its resource limit from $1000 to $2000. Such a change would protect families in the event that lump sum payments are treated as a resource, but would not provide protection against excess monthly income. Utah's draft state plan amendment specifically deemed diversion participants as Medicaid eligible by disregarding all income and resources for diversion participants during the diversion period. As such, Utah's state plan amendment offered the most specific consideration of diverted applicants in terms of their Medicaid eligibility.

Our research also suggested that certain states, specifically Utah and Montana, allowed for more generous treatment of income only in the case of those TANF applicants who also participated in a TANF diversion program. To the extent that states draw distinctions between Medicaid applicants who participate in diversion efforts and those who simply seek Medicaid, such selectivity would be considered by HCFA to be a violation of Medicaid's "comparability" law, which requires comparable treatment of all similarly situated families. However, because state SPAs were either missing or incomplete, it was not possible to know whether certain states were in fact extending more liberal standards for Medicaid only for selected subcategories of low income families with children.

In sum, most states appeared at the time of our study to have adjusted their Medicaid policies to take lump sum payments into account. However, this assertion frequently was oral, with no SPA to confirm it. Moreover, because detailed state plan amendments were lacking, it was not possible to know whether states were being selective in the categories of applicants for whom the more liberal treatment rules applied.

3. *Mandatory Applicant Job Search Diversion*

Table 4, which presents Medicaid data for states with mandatory job search requirements, shows that several states reported modification of earned income disregards as part of their section 1931 SPAs.

Whether modifications related to applicant income limits in fact help working applicants attain or maintain Medicaid eligibility depends upon several factors: (1) the degree of generosity of the earned income disregards and the timing of their application; (2) whether the disregards are available to applicants as well as recipients;[99] and (3) whether, as part of the application process, the state continues

---

[98] These states were Colorado, Maine, Montana, South Dakota, and Utah.

[99] States are allowed to distinguish between applicants and recipients only with respect to the earned income disregards because the AFDC-related rules allowed AFDC applicants and

to measure applicants' income against the upper income limits that previously applied to applicants under the AFDC-related methodologies that are shown in Table 1.

Of the sixteen states with mandatory applicant job search requirements, twelve states[100] had approved section 1931 state plan amendments. Three states[101] had amendments under review at the time of our study, and one state[102] had not submitted its state plan amendment, but had put more liberal methodologies into place as part of its welfare reform demonstration programs.

Table 4 indicates that six states[103] reported modifying their state plan amendments to liberalize their existing AFDC earned income methodologies under section 1931. In only three states[104] did the more generous earned income disregards appear to be available to applicants as well as recipients. Nevada appeared to offer the most generous earned income disregards, having replaced its standard AFDC earned income disregard with a disregard of all applicant earned income for three months, followed by a fifty percent disregard of gross earnings for the next nine months, and $90 or twenty percent of gross earnings (whichever is greater) for all months thereafter.

While the language in the state's 1931 SPA seems to indicate that this disregard is available only to individuals who were recipients of Medicaid in the immediately preceding month, discussions with state officials confirmed that this disregard was made available to applicants as well. At the same time, Nevada limited this new earned income disregard to applicants whose monthly earnings fell below a threshold earnings test of $817 for a family of three. This upper limit on earned income was less than the threshold upper limits in place under the AFDC-related methodologies.[105]

Arizona, while not as generous with its earned income disregards as Nevada, did make these disregards available to both applicants and recipients on an equal basis. Consequently, families with incomes up to fifty-one percent of the federal poverty level can qualify for Medicaid. Similarly, Oregon reported replacing its AFDC earnings disregards for recipients with a more generous disregard that is available to both applicants and recipients. Other states also reported expanding disregards for applicants as well as recipients.

---

recipients to be treated differently (the $90 or $30 and one-third of income disregard was available only for AFDC recipients).

[100] These states were Arizona, Arkansas, Georgia, Idaho, Kansas, Nevada, New York, Ohio, Oklahoma, Oregon, South Carolina, and Wisconsin.

[101] These states were Alabama, Indiana, and Missouri.

[102] This state was Maryland.

[103] These states were Arizona, Arkansas, Kansas, Nevada, New York, and Oregon.

[104] These states were Arizona, Nevada, and Oregon.

[105] *See infra* Table 1.

Despite the fact that a number of states reported altering their earnings disregards to aid applicants, the disregards were relatively restricted and created only limited additional eligibility. Furthermore, state responses to earned income disregard policy for Medicaid purposes show considerable variation. Table 4 illustrates the consequences of different earnings disregards for applicants and recipients in states with a mandatory applicant job search. In Kansas, applicant families with incomes up to forty-three percent of the federal poverty level can qualify for Medicaid, whereas recipient families with incomes up to sixty-seven percent of the FPL can qualify for medical assistance. Similarly, Arkansas policy provides twenty-two percent of the FPL for applicants and fifty-six percent for recipients. In New York, this difference is even more striking—fifty-one percent of the FPL for applicants and ninety-four percent of the FPL for recipients. In both cases (applicants and recipients), the treatment of earnings for Medicaid purposes is extremely limited. Despite the fact that the limitations are evident across the board, of particular concern is the failure on the part of states to make initial entry into the program possible for low income workers through their maintenance of extraordinarily limited earned income disregards.

As noted, the AFDC-related criteria include a threshold upper-income limit on the amount of income that applicants can have and still be permitted to apply for benefits. As also discussed, this limited upper income threshold is compounded by lower thresholds on the amount of income that applicants can maintain and still qualify for any aid under state AFDC eligibility policies. Thus, two important additional questions are first, whether states adjust the upper income limit for applicants who work, in order to allow them to move forward with an application at all, and second, whether the states adjust their net income tests to allow applicants to retain earned income and still qualify for Medicaid.

Our findings suggest that few states addressed this "gross income" and "net income" threshold eligibility test and that those that did often addressed only one aspect of the test. As Table 4 shows, Arkansas, for example, has eliminated the gross income test for applicants. At the same time, the state's net income standard for a family of three (the standard below which an applicant's income actually must fall in order to qualify for Medicaid) is twenty-two percent of the federal poverty level.[106] A family earning the minimum wage (which is significantly below the federal poverty level) would have income approximately four times the net income test used by Arkansas to determine Medicaid eligibility, since the net income test stands at twenty-two percent of the federal poverty level.

---

[106] *See infra* Table 1.

4. *Outreach and Enrollment Under Section 1931*

As discussed, how states actually administer their TANF and Medicaid programs is as important as the section 1931 eligibility criteria established by the states in determining families' ability to access Medicaid. This is particularly true for families participating in diversion programs that add yet another layer of complexity to ensuring access to, and determining eligibility for, Medicaid. Two fundamental factors can affect access: (1) whether individuals understand that they are eligible for Medicaid independent of their eligibility for TANF; and (2) the extent to which eligibility procedures and safeguards are in place to ensure that Medicaid applications are processed irrespective of the status of the TANF applications.

The interview findings from our study suggest that as of 1998, few states were making concerted efforts at outreach and education to ensure that low income parents understood that they (and not just their children) might be eligible for Medicaid without being eligible for (or even eligible to apply for) TANF. The central evidence of the failure on the part of states to encourage applications for Medicaid even as eligibility for TANF precludes the continued state practice of joint TANF-Medicaid applications. This effectively means that an application does not go forward unless an individual is applying for both programs. For example, while Colorado policy is that individuals who apply for diversion also complete a Medicaid application, a Colorado official noted that clients who sign the agreement assume that they are not eligible for Medicaid. Moreover, the Colorado official conceded that assuring the Medicaid application is completed for diverted applicants is a "problem area."

On the other hand, Wisconsin officials reported developing an extensive training effort for county staff, eligibility staff, and community-based organizations. In addition, Wisconsin hired an advertising agency to develop brochures, public service announcements for radio and television, and posters to "get the word out" about Medicaid. Wisconsin officials also mentioned an earlier failed effort to inform clients whose Medicaid case was closed that they still may be eligible for Medicaid. The state issued a mass mailing to seventeen thousand persons but it resulted in a considerable amount of mail returned undeliverable.

V. CONCLUSION: MEDICAID IN A CHANGING WELFARE SYSTEM

The 1996 welfare reform legislation fundamentally altered welfare, and in the process of doing so, fundamentally altered Medicaid as well. The Personal Responsibility and Work Opportunity Reconciliation Act empowered the states to replace the old welfare-to-work paradigm with one that turns on work-instead-of-welfare. Our analysis of diversion suggests that states have responded to this flexibility with enthusiasm and that the dramatic declines in welfare rolls can be

attributed less to sudden prosperity among the poor and more to the creation of elaborate barriers to assistance.

Even as lawmakers moved with enthusiasm to "end welfare as we know it,"[107] the evidence from the 1996 legislation suggests that they understood that even full-time work would not negate the need for public insurance. The statistics on health insurance coverage among the working poor were abysmal in 1996 and have improved only slightly since then.[108] As a result, lawmakers rejected the block granting of Medicaid and instead elected to preserve the program as an individual entitlement subject to minimum federal coverage standards.[109] Unfortunately, however, the standards that they chose to preserve were precisely the wrong ones.

The obvious question is how did such a basic mistake occur? An exceedingly poor understanding of Medicaid lies at the heart of the error. This limited grasp of the nation's largest public assistance program was compounded by the haste with which lawmakers acted in passing welfare reform and the virtual absence of careful analysis regarding the potential effects of certain policy choices. In their haste to preserve Medicaid in the face of the repeal of AFDC, lawmakers made an obvious choice—namely to preserve the existing AFDC-related rules for Medicaid. This choice turned out to be fundamentally wrong.

As this Article shows, the reasons why this was the wrong choice are very complex. The first reason concerns the working assumptions that lie at the heart of the AFDC methodology. AFDC is driven by income evaluation methodologies that are tied to welfare-to-work principles. When applied in a work-instead-of-welfare context, these methodologies turn out to punish the people who are being taught to play by different rules. A mother of three who comes to a welfare office and is told that she must find a job before she can apply for aid, who then finds a job that pays $500 a month, and who finally returns to file her TANF and Medicaid application, may find that the response that qualifies her for TANF now costs her Medicaid coverage because the Medicaid program has not adjusted its AFDC-related rules to take the world of work and earned income into account.

The second reason why the choice was wrong is tied to the administration of the program. Once families know that they cannot obtain aid from the welfare office until they find work and demonstrate self sufficiency, they simply may cease to seek aid. At this point, the basic means of entering Medicaid will potentially come to a halt, particularly if the Medicaid application remains wedded to the TANF application.

Medicaid was designed to piggyback on a "welfare-to-work" system of cash

---

[107] Address Before a Joint Session of Congress on Administration Goals, 1 PUB. PAPERS 113, 117 (Feb. 17, 1993).

[108] *See supra* note 6 and accompanying text.

[109] *See supra* notes 2–3 and accompanying text.

assistance. In changing the assistance system, Congress and the Administration simply neglected to change Medicaid and, indeed, locked the program into a repealed welfare methodological basis and mode of administration. Simply put, Medicaid as currently configured is basically incompatible with the new welfare system that is intended to produce workers, not recipients.

The net result of this basic error in policy is that a program which insures a quarter of the nation's children and millions of women has neither a methodological nor operational base in coverage of the working poor. The 1997 enactment of the State Children's Health Insurance Program (CHIP)[110] may mitigate the problem somewhat, at least in the case of children. This is because states that enroll children in CHIP must first assess their Medicaid eligibility and enroll them in Medicaid if they qualify. Furthermore, there is some evidence to suggest that CHIP has stimulated a greater level of program outreach as well as a simplification of eligibility criteria and application forms.

The real crisis at the moment is the uninsured low income parents of Medicaid and CHIP-eligible children and, in particular, single mothers who at one time qualified for AFDC and Medicaid and who are now caught between the "scylla" of the TANF work-instead-of-welfare paradigm and the "charybdis" of a Medicaid program that remains structured to reject low income workers who seek benefits.

Thus, there is an urgent need to restructure the income evaluation methodologies and application procedures on which the Medicaid program rests in order to favor low income workers. A number of states have now begun to engage in fundamental reassessment efforts. A few, most notably Oregon, Tennessee, and Massachusetts, have experimented since the early 1990s with demonstration programs that replace Medicaid as a welfare adjunct with a program of health insurance for low income workers. States could be further encouraged in this direction through enhanced federal financial contributions to the creation of public insurance programs for lower income workers and their families under section 1931 of the Social Security Act. Alternatively, of course, Congress could decide to simply require this basic restructuring or replace the existing Medicaid structure with a federalized program of subsidized health insurance for low income families.

What is clear is that profound shifts in national policy such as those which occurred under the 1996 welfare reform legislation have consequences that go far beyond the reform effort's immediately stated goals. The welfare reform legislation was enacted in haste and in a superheated political atmosphere, when reasonable discourse was minimal and maneuvering for political gains at the

---

110 *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 552-75 (1997) (codified at scattered sections of 42 U.S.C.).

expense of the poor was both accepted and indeed lauded.[111] The unforeseen consequences to Medicaid should serve as an object lesson regarding why such an approach to legislation is such a terrible thing. None of the implications were considered. The Congressional Budget Office did not even begin to understand the consequences for Medicaid, as its own completely incorrect cost estimates underscored.[112] Policy makers were not briefed on the intricate relationship between Medicaid and welfare, and approaches for avoiding the impact of Medicaid were not debated.[113] Potentially useful handles for liberalizing the Medicaid program to reach low income workers and their children were added to the statute,[114] but the old welfare paradigm was preserved as the basic rule for coverage.

One can only hope that as policy makers begin to confront the consequences of welfare reform for Medicaid, they will show a willingness to engage in the thoughtful dialogue regarding the program's future that should have occurred years ago.

---

111 *See supra* note 8 and accompanying text.

112 *See supra* note 8 and accompanying text.

113 *See supra* notes 3–6 and accompanying text.

114 *See supra* notes 67–70 and accompanying text.

TABLES

Table 1. Maximum Allowable Monthly Earnings for Working Medicaid Recipients (1997)
(Based on a three-person family with one wage earner. Assumes that the family's only source of income is earnings.)

State	Monthly Earnings Threshold	Earnings Threshold as a % of the Fed. Poverty Level	State (continued)	Monthly Earnings Threshold	Earnings Threshold as a % of the Fed. Poverty Level
Alabama	$253	22%	Montana	$833	73%
Alaska	$1,181	83%	Nebraska	$490	43%
Arizona	$584	51%	Nevada	$1,020	90%
Arkansas	$255	22%	New Hampshire	$686	60%
California	$864	76%	New Jersey	$533	47%
Colorado	$510	45%	New Mexico	$702	62%
Connecticut	$866	76%	New York	$666	59%
Delaware	$1,228	108%	North Carolina	$634	56%
District of Columbia	$2,275	200%	North Dakota	$845	74%
Florida	$392	34%	Ohio	$972	85%
Georgia	$513	45%	Oklahoma	$426	37%
Hawaii	$1,309	100%	Oregon	$1,138	100%
Idaho	$406	36%	Pennsylvania	$804	71%
Illinois	$597	52%	Rhode Island	$2.194	193%
Indiana	$377	33%	South Carolina	$658	58%
Iowa	$1,063	93%	South Dakota	$796	70%
Kansas	$493	43%	Tennessee	$766	67%
Kentucky	$615	54%	Texas	$364	32%
Louisiana	$263	23%	Utah	$657	58%
Maine	$1.227	108%	Vermont	$1,797	158%
Maryland	$523	46%	Virginia	$380	33%
Massachusetts	$1,513	133%	Washington	$1,090	96%
Michigan	$548	48%	West Virginia	$342	30%
Minnesota	$3,128	275%	Wisconsin	$737	65%
Mississippi	$457	40%	Wyoming	$789	69%
Missouri	$381	33%			
			Median State	$666	59%

Source: JOCELYN GUYER & CINDY MANN, CTR. ON BUDGET & POL'Y PRIORITIES, EMPLOYED BUT NOT INSURED (1999), at tbl.3.

Table 2. Dynamics of Medicaid Access Prior to and Following the 1996 Welfare Reform Amendments

Immediate enrollment of all eligible families in cash assistance; families automatically eligible for Medicaid	Diversion of many eligible families through lump sum payments and job searches; Medicaid eligibility thrown into question as lump sum and earned income push applicants' income above 1996 AFDC eligibility levels.
Period of cash assistance (typically between 6 and 12 months) accompanied by Medicaid.	Period of cash assistance (if any) very short – often less than 3 months; accompanying Medicaid coverage similarly may be limited to less than 3 months.
Transition from welfare to work; transitional Medicaid for families receiving welfare/Medicaid in 3 of 6 months preceding loss of welfare	Transitional Medicaid is available but fewer families qualify for failure to meet the 3/6 test.

Table 3. Categories of State Diversion Programs

State	Lump Sum	Alternative Resources	Job Search
Alabama			✓
Alaska			
Arizona			✓
Arkansas	✓		✓
California	✓		
Colorado	✓		
Connecticut			
Delaware			
District of Columbia			
Florida	✓	✓	
Georgia			✓
Hawaii			
Idaho	✓	✓	✓
Illinois			
Indiana			✓
Iowa	✓		
Kansas			✓
Kentucky	✓		
Louisiana			
Maine	✓		
Maryland	✓	✓	✓
Massachusetts			
Michigan			
Minnesota	✓		
Mississippi			
Missouri			✓
Montana	✓	✓	
Nebraska			
Nevada			✓
New Hampshire			
New Jersey			
New Mexico			
New York		✓	✓
North Carolina	✓		
North Dakota			
Ohio	✓		✓
Oklahoma			✓
Oregon			✓
Pennsylvania			
Rhode Island			
South Carolina			✓
South Dakota	✓		
Tennessee			
Texas	✓	✓	
Utah	✓		
Vermont			
Virginia	✓		
Washington	✓		
West Virginia	✓		
Wisconsin	✓	✓	✓
Wyoming			
Total	20	7	16

Source: K. Maloy et. al., A Description and Assessment of State Approaches to Diversion Programs and Activities Under Welfare Reform (Table 1-1)

Table 4. Treatment of Applicants with Earnings in States with Mandatory Applicant Job Search Diversion Programs

State	Previous Earned Income Methodology	Post-TANF Earned Income Methodology Under Section 1931		Earnings Threshold[116]	
		Applicants	Recipients	Under Old Methodology	Under New Methodology
	$90 disregard for Applicant and Recipient	Same as of July 16, 1996 standards - $90 disregard	Same as of July 16, 1996 standards - $90 disregard	22% FPL	22% FPL
	Disregards $90 plus $30 and 1/3 earned income for four months for Recipients	Disregards $90 plus 30% or $30 and 1/3 earned income (whichever greater) indefinitely	Disregards $90 plus 30% or $30 and 1/3 earned income (whichever greater) indefinitely	51% FPL	51% FPL
	Disregards $90 and $30 plus 1/3 for four months	Disregards 20% of earned income; Eliminates gross income test	Disregards 70% of earned income; excludes earnings from on-the-job or subsidized employment placements	22% FPL	56% FPL
	$90 disregard for Applicant and Recipient	Same as of July 16, 1996 standards - $90 disregard	Same as of July 16, 1996 standards - $90 disregard	45% FPL	45% FPL
	$90 disregard for Applicant and Recipient	Same as of July 16, 1996 standards - $90 disregard	Same as of July 16, 1996 standards - $90 disregard	36% FPL	36% FPL
	$90 disregard for Applicant and Recipient	Same as of July 16, 1996 standards - $90 disregard	Same as of July 16, 1996 standards - $90 disregard	33% FPL	33% FPL

[115] In the absence of specific language describing for how long these disregards are available, we assume that these disregards were or are available indefinitely.

[116] For the original data for these two columns see CINDY MANN & JOCELYN GUYER, THE CTR. ON BUDGET & POLICIES PRIORITIES, EMPLOYED BUT UNINSURED 11, 24 (1999). The earnings threshold is represented as a percentage of the Federal Poverty Level (FPL). It is important to note that Center on Budget and Policy Priorities' (CBPP) researchers do not or could not account for child care expenses disregards. This means that, in many states, the threshold is the floor and not the ceiling. See, for example, Table 4, at Nevada, which has a 90% FPL with earnings disregard, but actual child care costs are also deducted. Depending upon the circumstances of individual applicants, out-of-pocket child care expenses will push earnings threshold above the FPL percentages shown in Table 4.

State	Previous Earned Income Methodologies[115]	Earned Income Methodologies Under Section 1931		Earnings Threshold[116]	
		Applicants	Recipients	Applicants	Recipients
KS	Disregards $90 plus $30 and 1/3 earned income	$90 disregard	Disregards $90 plus 40% of earned income	43% FPL	67% FPL
MD [117]	Waiver established "in lieu of" policy; tag-a-long Medicaid	No 1931 SPA submitted	No 1931 SPA submitted		
MO	$90 disregard for Applicant and Recipient	$90 disregard	$90 disregard	33% FPL	33% FPL
MO [118]	$90 disregard for Applicant and Recipient	Missouri's 1115 waiver –MC+	Missouri's 1115 waiver –MC+	100% FPL	100% FPL
NV	Disregards $30 and 1/3 earned income for Recipients for whose net income without disregards does not exceed 100% need standard; disregard $90 plus $30 and 1/3 earned income for four months	Disregards all earned income for 3 months, then disregards 50% of earnings for next 9 months, but must pass net income test with just the $90 or 20% of earnings disregard	Disregards all earned income for 3 months, then disregards 50% of earnings for next 9 months, then disregards $90 or 20% of earned income (whichever greater) for subsequent months	90% FPL	90% FPL

[117] No entries are shown for Maryland because Maryland had not submitted a Section 1931 SPA at the time that Table 4 was compiled. Nevertheless, state officials reported continuing their Title IV-A waiver policies. State officials also reported applying a 20% earnings disregard to applicant families and a 26% earnings disregard to recipient families. Based on these specific disregards, the earnings thresholds for applicants and recipients would be 46% FPL and 48% FPL respectively.

[118] Missouri's 1115 waiver ("MC+") provides that families with incomes up to 100% FPL are eligible for Medicaid. Earnings disregards are also available for these families. Table 4 also shows two entries for Missouri, Oregon, and Wisconsin. This is because low-income families can access Medicaid in these states through either Section 1931 or the Section 1115 expansion.

State	Previous Earned Income Methodologies[115]	Earned Income Methodologies Under Section 1931		Earnings Threshold[116]	
		Applicants	Recipients	Applicants	Recipients
NY	Disregards $90 work expense for applicants plus $30 and 1/3 for Recipients	$90 disregard	Disregards 45% of earned income where gross family income does not exceed 100% FPL	51% FPL	94% FPL
OH	Disregards $250 and 50% of remainder of earned income for initial 18 months of AFDC	Disregards $250 and 50% of remainder of earned income	Disregards $250 and 50% of remainder of earned income[119]	85% FPL	85% FPL
OK	$120 disregard for Applicants and Recipients	Same as of July 16, 1996 standards - $120 disregard	Same as of July 16, 1996 standards - $120 disregard	37% FPL	37% FPL
OR	Disregards $30 and 1/3 for 4 months for Recipients	Disregards $90 plus $30 and 1/3 or 50% of earnings whichever greater	Disregards $90 plus $30 and 1/3 or 50% of earnings whichever greater	81% FPL	81% FPL
OR [120]	Disregards $30 and 1/3 for four months for Recipients	Oregon's 1115 waiver Oregon Health Plan	Oregon's 1115 waiver Oregon Health Plan	100% FPL	100% FPL
SC	Applicants $90 disregard, Recipients $100 disregard	Same as of July 16, 1996 standards - $90 disregard	Same as of July 16, 1996 standards - $100 disregard	59% FPL	59% FPL

[119] Although Ohio's Section 1931 SPA provides for an 18-month limit on recipient disregards, officials indicate that their Medicaid policy puts no limit on receipt of these disregards.

[120] Oregon's Section 1115 Medicaid waiver (the "Oregon Health Plan") provides persons with gross incomes up to 100% FPL to be eligible for Medicaid.

State	Previous Earned Income Methodologies[115]	Earned Income Methodologies Under Section 1931		Earnings Threshold[116]	
		Applicants	Recipients	Applicants	Recipients
WI	$90 disregard for Applicants and Recipients	$90 disregard	$90 plus any TANF income disregard	65% FPL	65% FPL
WI [121]	$90 disregard for Applicants and Recipients	Wisconsin's 1115 waiver BadgerCare	Wisconsin's 1115 waiver BadgerCare	185% FPL	185% FPL

[121] Wisconsin's 1115 waiver ("BadgerCare") went into effect in June 1999, and provides Medicaid to families with incomes up to 185% FPL. Earnings disregards are available to these families.